

S. No. 2  
M-5-43  
7. 5-17-39  
I X38671

State File No. \_\_\_\_\_

FILED JUL 2 1947

Registration District No. 1947

Primary Registration District No. 5710

Registrar's No. 3

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town rural Powell Center  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald

(c) City or town Powell Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Milas Alexander Jones

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6  
year 1947 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 5-29 1947 to June 6 1947  
that I last saw him alive on June 6 1947  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Margaret Jones

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 19 1866  
(Month) (Day) (Year)

Immediate cause of death myocarditis

Duration years

8. AGE: Years Months Days If less than one day

81 1 18 hr. min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace McDonald Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Samuel M Jones

13. Birthplace Ark.  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Fox

15. Birthplace Jenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Juanita Wildman

(b) Address Powell Mo. Route

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Fox Cemetery

18. (a) Signature of funeral director Wheaton Funeral Home

(b) Address Wheaton Mo.

19. (a) June 23, 47 (Date received local registrar) (b) D. C. Plummer (Registrar's signature) / 70

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury Q

23. Signature D. C. Plummer (M. D. or other \_\_\_\_\_)

Address Wheaton Mo. Date signed 6-9

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

*G. E. Culver*

Licensed Embalmer No.

*3584*

P. O. Address

*Cassville Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**